UHPP Comments and Initial Recommendations on the Department of Health’s ACO Contract Draft (“Draft”) dated August 7, 2012

◆ = specific recommendation to “set the table” for accountable care in Utah

General Recommendations and Next Steps

1. Call the Draft “Risk-Based Managed Care Contract Specifications for Utah’s Transition to Accountable Care” or something like this.
2. Create a business plan and timeline for moving Utah Medicaid toward Accountable Care to be incorporated in the new contract by January 1. The timeline specifies deadlines and parameters for the following:
   a. The formation of a quality and outcome measures working group to be convened by HealthInsight, Utah’s Quality Improvement Organization. Consumer and provider groups are represented in this working group and the meetings and proceedings are published on a website designated for Medicaid Reform.
   b. The formation of an ongoing public input process or working group.
3. Designate and seek a building block for a Medicaid Reform Director under the supervision of the Division of Health Care Financing Director. The building block should be sufficient for technical staff and any studies needed achieve the goals in the business plan.
4. Consider specific recommendations (“table setting measures”) in the table below.

<table>
<thead>
<tr>
<th>DRAFT CONTRACT SECTION</th>
<th>PROVISION SUMMARY</th>
<th>MEDICAID REFORM LEADERSHIP TEAM PRINCIPLES</th>
<th>☐=PROPOSED RECOMMENDATIONS with brief explanation</th>
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<tbody>
<tr>
<td>1.3, p3</td>
<td>Contract effective date January 1, 2013; contract termination date June 30, 2016</td>
<td>15. Align incentives for accountable care entities, providers, patients, and payers with desired outputs and health outcomes.</td>
<td>◆Provide for a series of optional extensions in the original term of contract language to incentivize plan performance. ◆ Make extensions contingent on plans meeting or exceeding the outcome benchmarks to be incorporated in the contract at a time specified in the timeline (see above), after start-up. Plans incur costs every time a new contract is initiated. Performance-based extension of the contract moves those costs over to the profit column.</td>
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<tr>
<td>3.2, p14</td>
<td>Prohibited marketing activities - Protects consumers against cold call marketing, misleading or inaccurate marketing materials</td>
<td></td>
<td>◆ The Department of Health (DOH) should require plans to meet state and federal statutory and regulatory requirements governing marketing to members and prospective enrollees. ◆ Policing of compliance with that requirement should be left to a collaborative process among the health plans. The effectiveness of that process should be reviewed by the Department after the first year of the contract. Early managed care experience with marketing abuses by plans led to stricter federal consumer protection standards. Monitoring</td>
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becomes more important as accountable care increases financial incentives for plans and their providers.

Member Handbook
- Requires that handbook include specified categories of information and outlines process for Department review and approval of text

4. A care delivery system that places the patient, their family/caregiver, and their primary care provider at the center of medical decision-making

5. Improved quality of care safely delivered by providers and accessed by patients at the right time in the right setting
6. Improved patient access to care through the recruitment of additional providers and the incorporation of health equity strategies in the model and its implementation

9. A medical or health home choice made by all patients and their families/caregivers
10. Operate with maximum transparency for patients and their families/caregivers, providers, and community stakeholders
14. Build a care delivery system that is responsive to the diverse care needs and life situations of the patient populations.
15. Align incentives for accountable care entities, providers, patients, and payers with desired outputs and health outcomes.
16. Provide patients and their families/caregivers with the consumer

◆ Member Handbook requirements should reflect the core role of appropriate, patient-centered care accessed at the right time, in the right place in the ACO model. DOH and the plans need to agree on the general criteria that patient-centered medical home should meet when implemented by the plans. The Department then would review each plan's implementation for consistency with those criteria.

Not addressed.

Not addressed.

Not addressed.

See cultural competency section—but still need more details on how this will be operationalized and monitored for quality and accountability to patients.

Not addressed.

Not addressed.
<table>
<thead>
<tr>
<th>Section</th>
<th>Requirement</th>
<th>Comment</th>
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<td>5.1.1, p 42</td>
<td><strong>Network Requirements</strong>&lt;br&gt;- Plan must consider anticipated enrollment and utilization of services, number and types of providers required, number of providers not accepting new patients, and geographic location (distance, travel time, means of transport, physical access for people with disabilities)</td>
<td>✦ Require plans to track and report to the state on a quarterly basis a network adequacy analysis that reflects the number of provider panels in the network that are open and closed to new patients, by provider type, etc.&lt;br&gt;✦ The Department should assume responsibility for reviewing those analyses in-house and then with the plans to determine corrective action plans as needed.&lt;br&gt;✦ Add: languages spoken&lt;br&gt;Current monitoring does not focus on the issue of open versus closed provider panels – plans have to indicate that information in the member handbook rather than report it to and have it analyzed by the department. It is not enough for providers to be present in a plan’s network if those providers are not accepting new patients. Provider accessibility will be critical to continuity and coordination of care on which the success of accountable care depends.</td>
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<td>5.1.6, p 44</td>
<td><strong>Timely Access Monitoring</strong>&lt;br&gt;- Plan to ensure Provider access compliance, monitor that compliance, and require corrective action as necessary</td>
<td>✦ The contract should reflect and further specify the Department's commitment to determining whether the plan has followed through on its obligation to ensure timely access to care in the right settings.&lt;br&gt;✦ The contract should specify timely access measures how these will be monitored over time. Payment methodologies (for example hold backs) should also be tied to these outcomes. <em>It is not enough to require plans to take corrective action in cases of provider failure to comply with timely access standards.</em></td>
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<td>5.3, p 46</td>
<td><strong>Contractor’s Selection of Providers</strong>&lt;br&gt;- Plan providers must be enrolled with Department as Medicaid providers, may not be excluded from participation in federal health care programs; plan must have written policies and procedures around selection, retention, credentialing, and recredentialing of providers; plan</td>
<td>✦ Not enough detail (for example: how would a patient or family member complain about any difficulty finding a provider to meet their needs?).&lt;br&gt;The contract does not stipulate any requirement that the contractor ensure that its network can be responsive to diverse care needs and life situations and that the Department will review and approve the contractor’s strategies for doing so. This is a critical prerequisite for the achievement of quality outcome goals across all</td>
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<tr>
<td>Section</td>
<td>Rule</td>
<td>Description</td>
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<td>5.3.10, p 48</td>
<td>Federally Qualified Health Centers</td>
<td>- Plan required to contract with at least one FQHC at rates comparable to those offered to similar non-FQHC providers</td>
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<td>6.1, p 49</td>
<td>Fraud, Waste and Abuse</td>
<td>11. Build the organizational capacity of accountable care entities to support accountability.</td>
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<td>6.6, p 59</td>
<td>Disclosure of Provider Incentive Plans</td>
<td>13. Transform the clinical process so that it integrates delivery of evidence-based care across all settings and services.</td>
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<td>10.2.4, p 84</td>
<td>Cultural Competence Requirements</td>
<td>12. Let any qualified and willing health care provider lead in clinical decision-making in the provision of high quality, cost effective, patient-centered care.</td>
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<td>10.3, p 85</td>
<td>Coordination and Continuity of Care</td>
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**5.3.10, p 48**

Federally Qualified Health Centers

- Plan required to contract with at least one FQHC at rates comparable to those offered to similar non-FQHC providers.

**6.1, p 49**

Fraud, Waste and Abuse

11. Build the organizational capacity of accountable care entities to support accountability.

**6.6, p 59**

Disclosure of Provider Incentive Plans

- Plan prohibited from making payments to physicians or physician groups as inducement to reduce or limit medically necessary services to a patient; must report provider incentive plans to the Department for review.

**10.2.4, p 84**

Cultural Competence Requirements

- Requires plan to: ensure delivery of care in culturally competent manner; incorporate cultural competency in policies, administration, delivery of services; foster cultural competency among providers; provide training to providers.

**10.3, p 85**

Coordination and Continuity of Care

- Requires coordination of care with other entities, including other health plans and prepaid mental health plans; ensuring each enrollee has ongoing source of primary care; educating providers on an effective model of coordinating physical and mental health services.

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- Plans should be required to offer to all Essential Community Providers as defined in the Affordable Care Act the same contract it offers to other providers and contract with those ECPs that agree to those terms.
- The plan’s administrative and management arrangements or procedures, including a mandatory compliance plan, should be subject to the review and approval of DOH working in conjunction with the OIG.
- This looks to be about regulatory compliance alone.
- The Department should outline its role in reviewing the contractors' incentive plans with providers to ensure that they meet accountable care criteria that the Department establishes up front.
- At a minimum, the Department should require each plan to submit a cultural competency plan that addresses a set of criteria established by the state. The state and the health plans should make good use of the evidence-based National Standards on Culturally and Linguistically Appropriate Services (CLAS). The Department then would review that plan against a readiness review tool that drills down on the kinds of activities that would be considered as meeting the cultural competency criteria.
- The draft contract contains minimally compliant competency rather than outcome-driven competency – the difference between the traditional MCO and ACO models.
- The draft requirements reflect approaches to coordination and continuity of care that are typical of traditional MCOs. There is no indication in this language that the Department expects the kind of integration, coordination, and continuity that would qualify an entity as an ACO organized around a medical home model (a definition of this would help as a starting point).
| No language | Quality Outcomes | 5. Improved quality of care safely delivered by providers and accessed by patients at the right time in the right setting  
7. Improved health outcomes  
8. Increased accountability in the Medicaid system  
15. Align incentives for accountable care entities, providers, patients, and payers with desired outputs and health outcomes. |
| No language | Plan Financial Incentives | 15. Align incentives for accountable care entities, providers, patients, and payers with desired outputs and health outcomes. |

outcomes.

17. Integrate care so that the needs of the whole patient are addressed.

direction of accountable care would be that the plans by 2014 begin pursuing and by 2015 have received NCQA ACO certification.

◆ The contract should also enumerate the responsibilities of the plans in coordinating with entities providing services that are explicitly carved out from the contract. Parallel enumeration of the entities’ responsibilities for coordination with the plans should be added to the carve-out entities’ contracts with the state and/or relevant counties.

No language | Quality Outcomes | 5. Improved quality of care safely delivered by providers and accessed by patients at the right time in the right setting  
7. Improved health outcomes  
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We understand that the Department and the plans intend to introduce second-generation, outcome-focused quality measures into the contract, perhaps as early as parallel to the planned six-month rate review. In the meantime, plans will be required to perform in relation to HEDIS and HEDIS-like measures that are part of the current contract.

◆ The contract that will be the basis for plans providing services beginning January 1, 2013 should include clear and specific language committing both parties to the timeline for introducing the new measures and a public process for their development.

The operational realities associated with beginning a new contract in four months mean that the current traditional MCOs will need to evolve into full-fledged ACOs during the term of the contract. As currently written, the contract includes no provisions that will ensure that that evolution happens.

◆ The contract that will be the basis for plans providing services beginning January 1, 2013 at a minimum should include financial incentives for the plans to make the transition to accountable care on a defined timeline. These incentives should be a mix of the following:

Non-financial

*Performance Profiling:* State reporting of ACO performance to the ACO, including comparisons with performance of other ACOs; possible posting of performance profiles to state website, available to public and stockholders

*Auto-Assignment Of New ACO Members:* For members who do not choose an ACO, auto assignment based on superior ACO performance in meeting transition deadlines.
| Financial | Experience Rebate Award: Provide for ACO retention of pre-tax income up to a set percentage of revenues, with income in excess of that percentage rebated to the state on a graduated scale; state option to raise the rebate threshold to reward outstanding performance in meeting transition deadlines.  
Capitation Percentage At Risk: ACOs paid full capitation amounts with review at the end of the rate period to determine whether ACO met at-risk-specific performance indicators as set out by the state; future capitation may be reduced by some portion of at-risk percentage, in the event of failure to perform; positive performance entitles ACO to retain at-risk percentage in the next rate period; failure timely to provide accurate data on performance measures results in assignment of 0% performance rate for each related indicator.  
TRANSITION CHALLENGE AWARD: Funds from capitation at-risk percentage retention by the state to be awarded to remaining ACOs that achieve superior performance in relation to transition challenge award-specific indicators developed by the state; failure timely to provide accurate data on performance measures results in assignment of 0% performance rate for each related indicator. |